

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0011544</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Meadows Mennonite Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/02</u> to <u>12/31/02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>Rural Route #1</u> <u>Chenoa</u> <u>61726</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>McLean</u>		(Signed) _____ (Date) _____	
Telephone Number: <u>(309) 747-2702</u> Fax # <u>(309) 747-2944</u>		(Type or Print Name) _____	
IDPA ID Number: <u>370791831001</u>		(Title) _____	
Date of Initial License for Current Owners: <u>1958</u>		(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____	
Type of Ownership:		(Print Name and Title) _____	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT		(Firm Name & Address) <u>Altschuler, Melvoin and Glasser, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>	
<input checked="" type="checkbox"/> Charitable Corp.		(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>	
<input type="checkbox"/> Trust		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
IRS Exemption Code <u>501 (c) 3</u>			
<input type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> GOVERNMENTAL			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Christine Hanover</u> Telephone Number: <u>(312) 634-3400</u> Please send copies of desk review and audit adjustments to address on this page			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadows Mennonite Home# 0011544 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>22</u>	Skilled (SNF)	<u>22</u>	<u>8,030</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>108</u>	Intermediate (ICF)	<u>108</u>	<u>39,420</u>	3
4		Intermediate/DD			4
5	<u>29</u>	Sheltered Care (SC)	<u>29</u>	<u>10,585</u>	5
6		ICF/DD 16 or Less			6
7	<u>159</u>	TOTALS	<u>159</u>	<u>58,035</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,293</u>	<u>4,160</u>		<u>7,453</u>	8
9	SNF/PED					9
10	ICF	<u>13,722</u>	<u>19,409</u>		<u>33,131</u>	10
11	ICF/DD					11
12	SC	<u>365</u>	<u>3,384</u>		<u>3,749</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,380</u>	<u>26,953</u>		<u>44,333</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 76.39%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒NO ☐

I. On what date did you start providing long term care at this location?

Date started 1958

J. Was the facility purchased or leased after January 1, 1978?

YES ☐Date NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐NO ☒

If YES, enter number

of beds certified 0 and days of care provided N/AMedicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	284,574	17,340	767	302,681		302,681		302,681			1
2	Food Purchase		272,784		272,784		272,784	(193)	272,591			2
3	Housekeeping	209,062	23,295	797	233,154		233,154		233,154			3
4	Laundry	39,860	19,161	15,446	74,467		74,467		74,467			4
5	Heat and Other Utilities			171,024	171,024		171,024		171,024			5
6	Maintenance	67,210	10,192	90,565	167,967		167,967		167,967			6
7	Other (specify):*											7
8	TOTAL General Services	600,706	342,772	278,599	1,222,077		1,222,077	(193)	1,221,884			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	1,793,016	82,648	293,053	2,168,717		2,168,717		2,168,717			10
10a	Therapy			14,776	14,776		14,776		14,776			10a
11	Activities	92,820	3,491	2,220	98,531		98,531	(1,591)	96,940			11
12	Social Services	87,259	472	25	87,756		87,756		87,756			12
13	Nurse Aide Training	1,169		1,165	2,334		2,334		2,334			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,974,264	86,611	316,039	2,376,914		2,376,914	(1,591)	2,375,323			16
	C. General Administration											
17	Administrative	120,900			120,900		120,900		120,900			17
18	Directors Fees											18
19	Professional Services			40,715	40,715		40,715		40,715			19
20	Dues, Fees, Subscriptions & Promotions			13,170	13,170		13,170		13,170			20
21	Clerical & General Office Expenses	198,885	11,004	52,925	262,814		262,814	(10,792)	252,022			21
22	Employee Benefits & Payroll Taxes			550,477	550,477		550,477		550,477			22
23	Inservice Training & Education			22	22		22		22			23
24	Travel and Seminar			8,722	8,722		8,722	(644)	8,078			24
25	Other Admin. Staff Transportation			6,387	6,387		6,387		6,387			25
26	Insurance-Prop.Liab.Malpractice			116,163	116,163		116,163		116,163			26
27	Other (specify):*											27
28	TOTAL General Administration	319,785	11,004	788,581	1,119,370		1,119,370	(11,436)	1,107,934			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,894,755	440,387	1,383,219	4,718,361		4,718,361	(13,220)	4,705,141			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**See schedule of adjustments attached at end of cost report.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			421,583	421,583		421,583	(15,102)	406,481			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			154,638	154,638		154,638	(13,173)	141,465			32
33	Real Estate Taxes			36,736	36,736		36,736	(36,736)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			92	92		92		92			35
36	Other (specify):*											36
37	TOTAL Ownership			613,049	613,049		613,049	(65,011)	548,038			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	20,547	645		21,192		21,192		21,192			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			71,175	71,175		71,175		71,175			42
43	Other (specify):* Nonallowable Costs	120,170	2,073	182,097	304,340		304,340	(304,340)				43
44	TOTAL Special Cost Centers	140,717	2,718	253,272	396,707		396,707	(304,340)	92,367			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,035,472	443,105	2,249,540	5,728,117		5,728,117	(382,571)	5,345,546			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

** See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Meadows Mennonite Home

0011544

Report Period Beginning:

01/01/02

Ending:

12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
NON-ALLOWABLE EXPENSES		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(193)	2		4
5 Telephone, TV & Radio in Resident Rooms	(34)	21		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	(15,102)	30		9
10 Interest and Other Investment Income	(13,173)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional				25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See Schedule 5A	(354,069)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (382,571)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)			34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (382,571)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39					39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name Meadows Mennonite Home
Provider # 0011544
Period Ending 12.31.2002

Schedule 5A

VI. Adjustment Detail
Line 29 - Other

Description	Amount	Schedule V Reference
Activity Income Offset	(1,591)	11
Miscellaneous Income Offset	(858)	21
Out of State Travel	(370)	24
Non-Patient Care Real Estate Taxes	(36,736)	33
Non-Allowable Cottage and Resident Expenses	(304,340)	43
CEO Housing	(9,900)	21
Development Department Travel & Seminar	(274)	24
Total	(354,069)	

See Accountants' Compilation Report

Meadows Mennonite Home

ID# 0011544

Report Period Beginning: 01/01/02

Ending: 12/31/02

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

12/31/02

12/31/02

[illegible]

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Meadows Mennonite Home

0011544

Report Period Beginning:

01/01/02

Ending:

12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(15,102)	0	0	0	0	0	0	0	0	0	0	(15,102)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,173)	0	0	0	0	0	0	0	0	0	0	(13,173)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(28,275)	0	0	0	0	0	0	0	0	0	0	(28,275)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(28,502)	0	0	0	0	0	0	0	0	0	0	(28,502)	45

Facility Name & ID Number Meadows Mennonite Home

0011544

Report Period Beginning:

01/01/02

Ending:

12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Meadows Mennonite Retirement Home	Meadows	Independent Living Housing

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2	N/A										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadows Mennonite Home

0011544

Report Period Beginning:

01/01/02

Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	N/A								2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadows Mennonite Home

0011544

Report Period Beginning:

01/01/02

Ending:

12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	GMAC		x	Mortgage	\$8,319.00	6/1976	\$ 1,620,000	\$ 772,620	6/2016	0.0500	\$ 40,051	1	
2	FMHA		x	Mortgage	\$9,876.00	2/1996	1,782,500	1,621,555	3/2028	0.0500	81,979	2	
3	Loyalty Loans		x	Prior Expansion		Various	13,500	13,500	Various	0.0700	910	3	
4	Commerce Bank		x	Auto Loan	\$377.00	11/1998	15,701		9/2003	0.0714	96	4	
5	See Schedule 9A				\$1,588.00		3,579,000	2,997,755			25,248	5	
	Working Capital												
6	Heartland Bank		x			6/2000	200,000	5,000	6/30/02	0.0760	6,354	6	
7												7	
8												8	
9	TOTAL Facility Related				\$20,160.00		\$ 7,210,701	\$ 5,410,430			\$ 154,638	9	
	B. Non-Facility Related*												
10												10	
11	Interest Income Offset										(13,173)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (13,173)	14	
15	TOTALS (line 9+line14)						\$ 7,210,701	\$ 5,410,430			\$ 141,465	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name Meadows Mennonite Home
 Provider # 0011544
 Period Ending 12.31.2002

Schedule 9A

IX. Interest Expense and Real Estate Tax Expense

Name of Lender	Related**		Purpose of Loan	Monthly	Date of	Amount of Note		Maturity	Interest	Reporting	
	YES	NO		Payment		Note	Original	Balance	Date	Rate	Period
				Required						(4 Digits)	Interest
Expense											
A. Direct Facility Related Long-Term											
Heartland Bank		x	Auto Loan	586	02/01/99	29,000	-	2/1/2004	0.0790	5	
Heartland Bank		x	Computer Upgrade	1,002	04/01/99	50,000	15,375	4/1/2004	0.0750	1,549	
Heartland Bank		x	Construction Loan		02/04/02	2,500,000	2,500,000	12/14/2034	0.0500	19,846	
Heartland Bank		x	Renovation		02/04/02	1,000,000	482,380	2/4/2033	Variable	3,848	
Total Facility Related				1,588		3,579,000	2,997,755			25,248	
Total Non-Facility Related				1,588		3,579,000	2,997,755			25,248	

See Accountants' Compilation Report

Facility Name & ID Number Meadows Mennonite Home

0011544 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1997	8		
	1998	9		
	1999	10		
	2000	11		
	2001	12		
			FOR OHF USE ONLY	
			13	FROM R. E. TAX STATEMENT FOR 2001 \$ 13
			14	PLUS APPEAL COST FROM LINE 5 \$ 14
			15	LESS REFUND FROM LINE 6 \$ 15
			16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Meadows Mennonite Home COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0011544

CONTACT PERSON REGARDING THIS REPORT Roger Hasler

TELEPHONE (309) 747-2702 FAX #: (309) 747-2944

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2. <u> </u>	<u>N/A</u>	\$ <u> </u>	\$ <u> </u>
3. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

A. Square Feet: 76,955

B. General Construction Type:

Exterior

Masonry

Frame

Wood, Brick, Steel

Number of Stories 2

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Meadows Mennonite Retirement Home Independent Living Housing

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred: N/A

2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	683,400	1920	\$ 15,065	1
2	Facility		1950	27,033	2
3	TOTALS	683,400		\$ 42,098	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadows Mennonite Home

0011544

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Bed*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4		1923	1923	\$ 74,144	\$		\$	\$	\$
5	23	1952	1952	86,314					
6	25	1966	1966	225,617					
7	94	1978	1978	2,348,846					
8	17	1997	1997	3,898,885					
Improvement Type**									
9	Various Building Improvements		1979	119,175					
10	Various Building Improvements		1980	15,029					
11	Various Building Improvements		1981	13,566					
12	Various Building Improvements		1982	1,645					
13	Various Building Improvements		1983	217,187		NOTE:			
14	Various Building Improvements		1984	6,839		DETAIL UNAVAILABLE			
15	Various Building Improvements		1985	31,287					
16	Various Building Improvements		1986	14,477					
17	Various Building Improvements		1987	15,979					
18	Various Building Improvements		1988	8,451					
19	Various Building Improvements		1989	24,261					
20	Various Building Improvements		1990	5,948					
21	Various Building Improvements		1991	10,093					
22	Various Building Improvements		1992	42,794					
23	Various Building Improvements		1993	28,059					
24	Various Building Improvements		1994	94,725					
25	Various Building Improvements		1995	48,021					
26	Engineering Cad & Survey		1996	675					
27	Excavating		1996	2,000					
28	Boiler Repair - Cleveland		1996	503					
29	Roof A/C Repair		1996	718					
30	Window Coverings		1996	1,039					
31	Sewage Pump Repairs		1996	1,685					
32	Siding		1997	22					
33	Siding		1997	245					
34	Carpet		1997	1,090					
35	Windows		1997	607					
36	2 Patios		1997	770					

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Landscaping	1997	\$ 957	\$		\$	\$	\$		37
38	Glass	1997	677							38
39	Service-Intercom System Repairs	1997	871							39
40	Fiber Optics - Computer Wiring	1997	2,887							40
41	Liquid Storage Cabinet Tank	1997	572							41
42	Paging System- Bennett	1997	2,288							42
43	Install Heating & Cooling	1997	15,161							43
44	Compressors	1997	692							44
45	Compressors	1997	961	NOTE: DETAIL UNAVAILABLE						45
46	Window Blinds	1997	1,539							46
47	Motor A/C Motor & Starter for 2 Ton Unit	1997	715							47
48	Repair Cool	1997	421							48
49	Repair Cool	1997	328							49
50	2 Roof top Units	1997	1,295							50
51	A/C Part Repairs	1997	733							51
52	Power Server	1997	150							52
53	Labor & Installation Units Rooftop A/C	1997	19,250							53
54	2 Carrier Heating & Cooling	1997	19,250							54
55	Intercom Wiring Repairs	1997	696							55
56	Carousel Tub	1997	12,423							56
57	Landscaping	1997	30,518							57
58	Curtains, Valances	1997	10,077							58
59	Patio Garden Landscaping	1997	12,842							59
60	Fence & Gate	1997	10,162							60
61	Telephone Wiring	1997	1,462							61
62	Draperies - Clark	1997	869							62
63	ASI Sign System	1997	2,547							63
64	Rocks For 2 Courtyards	1998	2,070							64
65	Asphalt Maintenance	1998	5,500							65
66	Window Room # 51	1998	444							66
67	Magnetic Gate Contact	1998	228							67
68	Carpet Restroom	1998	330							68
69	Carpet 3 Rooms	1998	793							69
70	TOTAL (lines 4 thru 69)		\$ 7,500,404	\$		\$	\$	\$		70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,500,404	\$		\$	\$	\$	1
2	Maintenance Shop	1998	909						2
3	2 A/C Compressors	1998	1,006						3
4	Heat & Air Thermostat	1998	1,410						4
5	Natural Gas Steamer	1998	7,495	NOTE: DETAIL UNAVAILABLE					5
6	Heat Duct Repair	1998	761						6
7	Repair Engine & Generator	1998	1,322						7
8	Alarm System Phase I	1998	44,529						8
9	Sewage Pump Rehab	1998	7,208						9
10	Water Tower Rehab	1998	63,699						10
11	OSHA Upgrades	1998	111						11
12	Required OSHA Items	1998	458						12
13	Eye Wash Station	1998	585						13
14	1 CS Spill Kits	1998	122						14
15	Repair Roadway	1999	3,500						15
16	Landscaping Improvements	1999	2,259						16
17	Station 1 Door Keypads	1999	1,442						17
18	Station 1 Code Alert System	1999	15,298						18
19	Station 1 Nurse Call System	1999	11,924						19
20	Ceiling Installation	1999	1,945						20
21	Improvements to Brown Shed	1999	1,288						21
22	Safety Bars in Alzheimer's Unit	1999	2,350						22
23	Bronze Door & Closer	1999	1,806						23
24	Hardware for Existing Doors in Alzheimer's Unit	1999	5,536						24
25	Sensor Base for Alarm	1999	231						25
26	Repair Boiler Station 4	1999	1,140						26
27	Repair Generator	1999	3,067						27
28	Water Heater for Kitchen	1999	878						28
29	Panic Devices on Doors in Alzheimer Unit	1999	688						29
30	Alarm System	1999	7,562						30
31	Storage Cabinets & Installation	1999	5,242						31
32	Elevator Eye	1999	1,978						32
33	Fire Alarm System Materials & Labor	1999	27,650						33
34	TOTAL (lines 1 thru 33)		\$ 7,725,803	\$		\$	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 7,725,803	\$		\$	\$	\$	1
2	Compressor for Freezer	1999	1,809						2
3	Sewer Improvements (Check Valves)	1999	1,312						3
4	New Pipes in Well	1999	921						4
5	New Alzheimer Unit Sign	1999	1,144						5
6	Station 4 Door Seal Parts & Labor	1999	1,163	NOTE: DETAIL UNAVAILABLE					6
7	Carpet - Station 5	2000	1,126						7
8	Station 5 Remodel	2000	320						8
9	Station 5 Tile	2000	530						9
10	Bathroom Fixtures - Station 5	2000	1,675						10
11	Garage Door Enlargement	2000	1,276						11
12	Elevator Cylinder	2000	16,746						12
13	Fire Alarm System	2000	18,000						13
14	Mastercare Hydrobath	2000	9,490						14
15	Door Locks on Soiled Linen Closet	2000	568						15
16	Air Conditioner Motor	2000	657						16
17	Air Conditioner Compressor	2000	1,732						17
18	Alarm System	2000	35,000						18
19	Alarm System	2000	18,060						19
20	Alarm System Sensor	2000	864						20
21	Premium Lawn	2000	755						21
22	Parking Lot Addition	2000	7,355						22
23	New Controller for Sewer	2000	1,573						23
24	Sewer Improvements	2000	752						24
25	Water Main Work	2000	2,203						25
26	Water Main Extension	2000	8,465						26
27	Chlorinator	2000	1,389						27
28	Generator Repair	2001	506						28
29	Generator Repair/Trans.	2001	1,434						29
30	Boiler Repair	2001	1,044						30
31	Air Conditioner Compressor	2001	700						31
32	Air Conditioner Compressor	2001	1,200						32
33	Storm Windows	2001	2,071						33
34	TOTAL (lines 1 thru 33)		\$ 7,867,643	\$		\$	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,867,643	\$		\$	\$	\$	1
2	Simplex Fire Alarm	2001	763						2
3	Building Phase II Renovation	2002	2,863,687						3
4	Garage Doors	2002	1,166						4
5	Roof	2002	125,025						5
6	Windows	2002	1,063						6
7	Water Heater	2002	4,599						7
8	Generator	2002	1,565						8
9	Air Conditioner	2002	6,645						9
10	Heating	2002	1,424						10
11	Air Hood	2002	4,970						11
12	Fire Protection System	2002	2,572						12
13	Vent Ducts	2002	830						13
14	New Road	2002	3,911						14
15	Lift/Pump Station	2002	12,330						15
16									16
17									17
18									18
19	NOTE: DETAIL UNAVAILABLE			319,533		319,533		3,719,608	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,898,193	\$ 319,533		\$ 319,533	\$	\$ 3,719,608	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 431,742	\$ 68,996	\$ 68,996	\$	3-25 years	\$ 243,076	71
72	Current Year Purchases	210,166	17,952	17,952		3-7 years	17,952	72
73	Fully Depreciated Assets	646,488				Various	646,488	73
74								74
75	TOTALS	\$ 1,288,396	\$ 86,948	\$ 86,948	\$		\$ 907,516	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		N/A		\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 12,228,687	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 406,481	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 406,481	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,627,124	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Residential Housing Units	\$ 1,361,649	\$	\$ 784,346	86
87	Residential Vehicles	75,508		53,485	87
88	CEO House Remodeling	70,602		30,407	88
89	Land	175,524			89
90					90
91	TOTALS	\$ 1,683,283	\$	\$ 868,238	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A.

N/A

N/A

9. Option to Buy: ☐ YES ☒ NO Terms: N/A*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 92

Description: Dishwasher

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$ N/A

13. /2004 \$ N/A

14. /2005 \$ N/A

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
		IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
		IN OTHER FACILITY <input checked="" type="checkbox"/>	IN OTHER FACILITY <input checked="" type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE <u>40</u>
		HOURS PER AIDE <u>112</u>	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	875	\$	875
2	Books and Supplies		90		90
3	Classroom Wages (a)		1,169		1,169
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		200		200
9	TOTALS	\$	2,334	\$	2,334
10	SUM OF line 9, col. 1 and 2 (e)	\$	2,334		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ None

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	5

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name Meadows Mennonite Home
Provider # 0011544
Period Ending 12.31.2002

XIII. Expenses Relating to Nurse Aide Training Programs

Wages:

M. Schrenk	876
H. Metz	293
	<u>1,169</u>

Tuition: - Livingston Area Vocational

Thracher	275
M. Schrenk	300
H. Metz	300
	<u>875</u>

Test: - Southern Illinois Universtiy

Kemp	50
Payton	50
M. Schrenk	50
H. Metz	50
	<u>200</u>

Books:

M. Schrenk	45
H. Metz	45
	<u>90</u>

<u>Total Expenses</u>	<u>2,334</u>
-----------------------	--------------

See Accountants' Compilation Report

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
10	Academic Education		hrs							11
11	Exceptional Care Program									12
12										
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Meadows Mennonite Home

0011544

Report Period Beginning: 01/01/02

Ending:

12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 885,052	\$ 885,052	1
2	Cash-Patient Deposits	14,465	14,465	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>None</u>)	332,900	332,900	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,353	1,353	6
7	Other Prepaid Expenses	25,852	25,852	7
8	Accounts Receivable (owners or related parties)	130,273	130,273	8
9	Other(specify): <u>Show Bus Non-Patient Care</u>	12,396		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,402,291	\$ 1,389,895	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	603,425	603,425	12
13	Land	217,622	42,098	13
14	Buildings, at Historical Cost	11,675,479	10,898,193	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,651,194	1,288,396	16
17	Accumulated Depreciation (book methods)	(4,680,608)	(4,627,124)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: <u>See Sch 17A</u>)	617,498		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 10,084,610	\$ 8,204,988	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,486,901	\$ 9,594,883	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 151,730	\$ 151,730	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,193	13,193	28
29	Short-Term Notes Payable	153,888	153,888	29
30	Accrued Salaries Payable	23,316	23,316	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,436	18,436	31
32	Accrued Real Estate Taxes(Sch.IX-B)	34,220		32
33	Accrued Interest Payable	114,751	114,751	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	258,258	258,258	36
37	<u>Showbus Payables</u>	5,653	5,653	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 773,445	\$ 739,225	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,961,886	2,961,886	39
40	Mortgage Payable	2,294,656	2,294,656	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Non Patient Care Notes</u>	891,643		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,148,185	\$ 5,256,542	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,921,630	\$ 5,995,767	46
47	TOTAL EQUITY (page 18, line 24)	\$ 4,565,271	\$ 3,599,116	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,486,901	\$ 9,594,883	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Facility Name Meadows Mennonite Home
Provider # 0011544
Period Ending 12.31.2002

Schedule 17A

XV. Balance Sheet

A. Other Long-Term Assets
Line 22, Other (specify)

	Operating	After Consolidation
Rental Property	577,303	-
CEO Housing Remodeling	40,195	-
Total	617,498	-

C. Current Liabilities
Line 36, Other Current Liabilities (specify):

	Operating	After Consolidation
Sick/Bonus/Christmas	11,610	11,610
Federal Tax Withholdings	13,249	13,249
State Tax Withholdings	3,367	3,367
ETO/Bonus' Payable	208,610	208,610
403(b) Annuity	20,175	20,175
Trust Application Deposit	1,030	1,030
Miscellaneous	217	217
Total	258,258	258,258

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,526,475	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,526,475	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	38,799	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 38,799	17
	B. Transfers (Itemize):		
18	Rounding	(3)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (3)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,565,271	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Meadows Mennonite Home

0011544

Report Period Beginning: 01/01/02

Ending:

12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,664,640	1
2	Discounts and Allowances for all Levels	(746,572)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,918,068	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	19,597	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 19,597	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	21,575	13
14	Non-Patient Meals	193	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	95,614	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 117,382	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	13,173	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,173	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	698,696	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 698,696	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,766,916	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	1,222,077	31
32	Health Care	2,376,914	32
33	General Administration	1,119,370	33
B. Capital Expense			
34	Ownership	613,049	34
C. Ancillary Expense			
35	Special Cost Centers	325,532	35
36	Provider Participation Fee	71,175	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,728,117	40
41	Income before Income Taxes (line 30 minus line 40)**	38,799	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 38,799	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name Meadows Mennonite Home
Provider # 0011544
Period Ending 12.31.2002

Schedule 19A

XVII. Income Statement

E. Other Revenue

	<u>Amount</u>
Residential	231,861
Admission Fees	31,020
Wanderguard	4,075
Designated - Memorials	20,765
Designated - Other	13,694
Undesignated - Memorials	3,793
Undesignated - Other	20,477
Estate and Trust Contributions	208,166
Gifts in Kind	16,298
Gain on Sale of Investment	4,288
Residential Assistance	7,500
Property Damage	91,810
Miscellaneous	858
Administrative Services Reimbursement	7,200
CFO Reimbursement	2,700
Activity Crafts Income	1,591
Telephone & Fax Income	34
Fundraising Income	882
Rental Income	31,684
Total	<u>\$ 698,696</u>

See Accountants' Compilation Report

Facility Name & ID Number Meadows Mennonite Home

0011544

Report Period Beginning: 01/01/02

Ending:

12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,960	2,160	\$ 46,431	\$ 21.50	1
2	Assistant Director of Nursing	1,945	2,183	40,903	18.74	2
3	Registered Nurses	16,614	17,938	336,780	18.77	3
4	Licensed Practical Nurses	16,873	18,560	304,744	16.42	4
5	Nurse Aides & Orderlies	84,422	92,142	1,019,968	11.07	5
6	Nurse Aide Trainees	106	118	1,169	9.91	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,068	2,229	20,975	9.41	8
9	Activity Director	1,760	1,944	22,048	11.34	9
10	Activity Assistants	8,541	9,395	70,772	7.53	10
11	Social Service Workers	3,409	3,908	53,118	13.59	11
12	Dietician					12
13	Food Service Supervisor	3,070	3,456	48,736	14.10	13
14	Head Cook	9,302	9,971	88,993	8.93	14
15	Cook Helpers/Assistants	20,917	22,566	146,845	6.51	15
16	Dishwashers					16
17	Maintenance Workers	4,478	4,897	67,210	13.72	17
18	Housekeepers	22,266	24,484	209,062	8.54	18
19	Laundry	4,732	5,185	39,860	7.69	19
20	Administrator	1,709	2,078	53,935	25.96	20
21	Assistant Administrator					21
22	Other Administrative	1,313	1,491	66,965	44.91	22
23	Office Manager	2,070	2,317	57,907	24.99	23
24	Clerical	9,039	9,955	140,978	14.16	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: See Sch 20A	3,259	3,967	57,356	14.46	32
33	Other(specify) See Sch 20A	10,729	11,812	140,717	11.91	33
34	TOTAL (lines 1 - 33)	230,582	252,756	\$ 3,035,472 *	\$ 12.01	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	4,800	L9, C3	36
37	Medical Records Consultant	Monthly	1,440	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	600	L10, C3	39
40	Physical Therapy Consultant	208	11,123	L10a, C3	40
41	Occupational Therapy Consultant	121	3,328	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	5	325	L10a, C3	43
44	Activity Consultant	13	1,568	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	347	\$ 23,184		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,354	\$ 95,970	L10, C3	50
51	Licensed Practical Nurses	570	20,340	L10, C3	51
52	Nurse Aides	6,987	173,416	L10, C3	52
53	TOTAL (lines 50 - 52)	9,911	\$ 289,726		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name	Meadows Mennonite Home
Provider #	0011544
Period Ending	12.31.2002

Schedule 20A

XVIII. Staffing & Salary Costs

	Hours Worked	Hours Paid	Salary	Avg. Hr Wage	Cost Report Line
Nursing Scheduler	2,059	2,211	23,215	10.50	10
Chaplain	1,200	1,756	34,141	19.44	12
Total - Line 31 - Other Health Care	3,259	3,967	57,356	14.46	
Development Director	864	982	29,221	29.76	43
Residential Services	7,224	7,958	80,578	10.13	43
Campus Director	1,088	1,144	10,371	9.07	43
Beautician	1,553	1,728	20,547	11.89	40
Total - Line 33 - Other	10,729	11,812	140,717	11.91	

See Accountants' Compilation Report

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount				
Nancy Stedman	Administrator	0	\$ 53,935	Workers' Compensation Insurance	\$ 54,225	IDPH License Fee	\$				
Robert O. Bertsche	CEO	0	66,965	Unemployment Compensation Insurance	4,114	Advertising; Employee Recruitment	2,207				
				FICA Taxes	229,624	Health Care Worker Background Check (Indicate # of checks performed <u>58</u>)	697				
				Employee Health Insurance	198,637	LSN	7,313				
				Employee Meals		Mennonite Health Service	1,087				
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues	568				
				403B Annuity	51,971	Miscellaneous Subscriptions	1,298				
				Group Life Insurance	4,698						
				Sick Pay	(11,000)						
				Employee Benefits Admin. Fee	4,222						
				Employee Relations	1,535	Less: Public Relations Expense	(
				Bonuses	11,371	Non-allowable advertising	(
				Vaccines	1,080	Yellow page advertising	(
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 120,900	TOTAL (agree to Schedule V, line 22, col.8)	\$ 550,477	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 13,170				
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
Description			Amount	Description	Line #	Amount	Description	Amount			
N/A			\$	N/A		\$	Out-of-State Travel	\$			
							In-State Travel				
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				See Attached Schedule	8,078			
C. Professional Services							Seminar Expense				
Vendor/Payee	Type		Amount								
Heinold-Banwart, LTD	Accounting		\$ 10,800								
Altschuler, Melvoin &											
Glasser, LLP	Accounting		4,100								
Quality Business Solutions	Computer		525								
Advanced Information Systems	Computer		9,273								
Michael Stedman	Computer		1,494								
Wellspring	Consulting		2,047								
Wellspring Innovative Solutions	Consulting		12,476								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 40,715	TOTAL		\$	Entertainment Expense	(
							(agree to Sch. V, line 24, col. 8)				
							TOTAL	\$ 8,078			

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadows Mennonite Home

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network - \$7,313
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 51,279 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 71,175
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? N/A For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 193
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Heinold-Banwart, Ltd. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT

Meadows Mennonite Hos

03:37 PM

11/04/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	Explanation	COMPARE CELL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-382,571	equal to	-382,571	0	O.K.		Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	141,465	equal to	141,465	0	O.K.		Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.		Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!		Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	406,481	equal to	406,481	0	O.K.		Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.		Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	92	equal to	92	0	O.K.		Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	2,334	equal to	2,334	0	O.K.		Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv. - Staff Wages		equal to		0	O.K.		Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	14,776	equal to	14,776	0	O.K.		Pg16 Z12+Z14..Z16 & Pg 20 X17..X20	N/A,B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv. - Supplies		equal to	#VALUE!	#VALUE!	#VALUE!		Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,222,077	equal to	1,222,077	0	O.K.		Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	2,376,914	equal to	2,376,914	0	O.K.		Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,119,370	equal to	1,119,370	0	O.K.		Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	613,049	equal to	613,049	0	O.K.		Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	325,532	equal to	325,532	0	O.K.		Pg19 P17	N/A	35	2	Pg4 H21..H24++	N/A	38to41+43	4
Income Stat. Prov. Partic.	71,175	equal to	71,175	0	O.K.		Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,748,826	equal to	1,793,016	-44,190	FAILED	See p20 K11-18 & sch20a - Nurse Scheduler	Pg20 K11..K15+K35+K36+K38..K44	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	1,169	< or = to	1,169	0	O.K.		Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.		Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	92,820	equal to	92,820	0	O.K.		Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	53,118	equal to	87,259	-34,141	FAILED	Chaplin Salary	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	284,574	equal to	284,574	0	O.K.		Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	67,210	equal to	67,210	0	O.K.		Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	209,062	equal to	209,062	0	O.K.		Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	39,860	equal to	39,860	0	O.K.		Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	120,900	equal to	120,900	0	O.K.		Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	198,885	equal to	198,885	0	O.K.	See dev dir salaries sch20a	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.		Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	3,035,472	equal to	3,035,472	0	O.K.		Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to	767	-767	O.K.	Minor equipment	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	4,800	< or = to	4,800	0	O.K.		Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	291,766	< or = to	293,053	-1,287	O.K.	minor equipment	Pg20 X14..X16+X37..X39	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	1,568	< or = to	2,220	-652	O.K.	minor equipment & piano tuning	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to	25	-25	O.K.	minor equipment	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	120,900	equal to	120,900	0	O.K.		Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.		Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	40,715	equal to	40,715	0	O.K.		Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	550,477	equal to	550,477	0	O.K.		Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	13,170	equal to	13,170	0	O.K.		Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	8,078	equal to	8,078	0	O.K.		Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	71,175	equal to	71,175	0	O.K.		Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	0	0	O.K.		Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.		Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	1,169	equal to	1,169	0	O.K.		Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	N/A	equal to	0	#VALUE!	#VALUE!		Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs		equal to	0	#VALUE!	#VALUE!		Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4C	B.	14	8
Total loan balance	5,410,430	equal to	5,410,430	0	O.K.		Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to	0	0	O.K.		Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	42,098	equal to	42,098	0	O.K.		Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	10,898,193	equal to	10,898,193	0	O.K.		Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	1,288,396	equal to	1,288,396	0	O.K.		Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	4,627,124	equal to	4,627,124	0	O.K.		Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	4,565,271	equal to	4,565,271	0	O.K.		Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	38,799	equal to	38,799	0	O.K.		Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.		Pg22 F31-J31..S31	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	11,486,901	equal to	11,486,901	0	O.K.		Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustmen	Adjusted Total
1. Dietary	284,574	17,340	767	302,681	0	302,681	0	302,681
2. Food P	0	272,784	0	272,784	0	272,784	-193	272,591
3. Housek	209,062	23,295	797	233,154	0	233,154	0	233,154
4. Laundr	39,860	19,161	15,446	74,467	0	74,467	0	74,467
5. Heat ar	0	0	171,024	171,024	0	171,024	0	171,024
6. Mainte	67,210	10,192	90,565	167,967	0	167,967	0	167,967
7. Other (0	0	0	0	0	0	0	0
8. Total G	600,706	342,772	278,599	1,222,077	0	1,222,077	-193	1,221,884
9. Medical	0	0	4,800	4,800	0	4,800	0	4,800
10. Nursin	1,793,016	82,648	293,053	2,168,717	0	2,168,717	0	2,168,717
10a. Ther	0	0	14,776	14,776	0	14,776	0	14,776
11. Activi	92,820	3,491	2,220	98,531	0	98,531	-1,591	96,940
12. Social	87,259	472	25	87,756	0	87,756	0	87,756
13. Nurse	1,169	0	1,165	2,334	0	2,334	0	2,334
14. Progr	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total I	1,974,264	86,611	316,039	2,376,914	0	2,376,914	-1,591	2,375,323
17. Admin	120,900	0	0	120,900	0	120,900	0	120,900
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	40,715	40,715	0	40,715	0	40,715
20. Fees,	0	0	13,170	13,170	0	13,170	0	13,170
21. Cleric	198,885	11,004	52,925	262,814	0	262,814	-10,792	252,022
22. Emplo	0	0	550,477	550,477	0	550,477	0	550,477
23. Inserv	0	0	22	22	0	22	0	22
24. Travel	0	0	8,722	8,722	0	8,722	-644	8,078
25. Other	0	0	6,387	6,387	0	6,387	0	6,387
26. Insura	0	0	116,163	116,163	0	116,163	0	116,163
27. Other	0	0	0	0	0	0	0	0
28. Total C	319,785	11,004	788,581	1,119,370	0	1,119,370	-11,436	1,107,934
29. Total C	2,894,755	440,387	1,383,219	4,718,361	0	4,718,361	-13,220	4,705,141
30. Depre	0	0	421,583	421,583	0	421,583	-15,102	406,481
31. Amort	0	0	0	0	0	0	0	0
32. Intere	0	0	154,638	154,638	0	154,638	-13,173	141,465
33. Real E	0	0	36,736	36,736	0	36,736	-36,736	0
34. Rent -	0	0	0	0	0	0	0	0
35. Rent -	0	0	92	92	0	92	0	92
36. Other	0	0	0	0	0	0	0	0
37. Total C	0	0	613,049	613,049	0	613,049	-65,011	548,038
38. Medic	0	0	0	0	0	0	0	0
39. Ancill	0	0	0	0	0	0	0	0
40. Barber	20,547	645	0	21,192	0	21,192	0	21,192
41. Coffee	0	0	0	0	0	0	0	0
42. Provid	0	0	71,175	71,175	0	71,175	0	71,175
43. Other	120,170	2,073	182,097	304,340	0	304,340	-304,340	0
44. Total S	140,717	2,718	253,272	396,707	0	396,707	-304,340	92,367
45. Grand	3,035,472	443,105	2,249,540	5,728,117	0	5,728,117	-382,571	5,345,546

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	885,052	885,052
2. Cash - Patient Deposits	14,465	14,465
3. Accounts & Notes Receivable	332,900	332,900
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	1,353	1,353
7. Other Prepaid Expenses	25,852	25,852
8. Accounts Receivable-Owner/Related Party	130,273	130,273
9. Other (specify):	12,396	0
10. Total current assets	1,402,291	1,389,895
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	603,425	603,425
13. Land	217,622	42,098
14. Buildings, at Historical Cost	11,675,479	10,898,193
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	1,651,194	1,288,396
17. Accumulated Depreciation (book methods)	-4,680,608	-4,627,124
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	617,498	0
23. other (specify):	0	0
24. Total Long-Term Assets	10,084,610	8,204,988
25. Total Assets	11,486,901	9,594,883
CURRENT LIABILITIES		
26. Accounts Payable	151,730	151,730
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	13,193	13,193
29. Short-Term Notes Payable	153,888	153,888
30. Accrued Salaries Payable	23,316	23,316
31. Accrued Taxes Payable	18,436	18,436
32. Accrued Real Estate Taxes	34,220	0
33. Accrued Interest Payable	114,751	114,751
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	258,258	258,258
37. Other Current Liabilities (specify):	5,653	5,653
38. Total Current Liabilities	773,445	739,225
LONG TERM LIABILITES		
39. Long-Term Notes Payable	2,961,886	2,961,886
40. Mortgage Payable	2,294,656	2,294,656
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	891,643	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	6,148,185	5,256,542
46. Total Liabilities	6,921,630	5,995,767
47. Total Equity	4,565,271	3,599,116
48. Total Liabilities and Equity	11,486,901	9,594,883

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	5,664,640
2. Discounts and Allowances for all Levels	-746,572
Subtotal - Inpatient Care	4,918,068
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	19,597
7. Oxygen	0
Subtotal - Ancillary Revenue	19,597
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	21,575
14. Non-Patient Meals	193
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	95,614
22. Laundry	0
Subtotal - Other Operating Revenue	117,382
24. Contributions	0
25. Interest and Other Investments Income	13,173
Subtotal - Non-Operating Revenue	13,173
27. Other Revenue (specify):	698,696
28. Other Revenue (specify):	0
Subtotal - Other Revenue	698,696
30. Total Revenue	5,766,916
31. General Services	1,222,077
32. Health Care	2,376,914
33. General Administration	1,119,370
34. Ownership	613,049
35. Special Cost Centers	325,532
35. Provider Participation Fee	71,175
37. Other	0
40. Total Expenses	5,728,117
41. Income Before Income Taxes	38,799
42. Income Taxes	0
43. Net Income or Loss for the Year	38,799

Page

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9 Line 16 for mortgage insurance.

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